"We're all in an abusive relationship with the health-care system": Collective memories of transgender health care

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Collective memory work allows participants to recall, examine, and analyze their memories and experiences within a broader cultural context to see how their individual experiences link to collective, shared experiences of similar and/or different groups. This study utilized collective memory work to engage six trans participants in an examination of their individual experiences with health care. During a four-hour focus group, participants engaged in this process of discourse analysis and came to collective agreements about the meaning of their stories, the intentions of the author, and the intentions of others in their shared lived experience. In this paper, we will provide a thorough and rich description of the participants' memories and their collective analysis, which highlights the interconnection between perceptions of oneself and their experiences with the health-care system. Our analysis revealed participants felt they had a toxic relationship with the health-care system. In particular, they discussed how health-care professionals left trans people tremulously asking for services, uncertain if they would receive care, what the quality of the care would be, and whether they would be treated respectfully. When discussing positive health-care experiences, participants highlighted when fears and anxieties were not realized, but all instances reflected some inappropriate actions. The results from this study will contribute to research on trans health care by providing a nuanced understanding of how health-care experiences impact trans communities collectively, as well as the ways in which health practices can be improved.

KEYWORDS: Collective memory work, gender non-conforming, health, health care, health systems, non-binary, transgender

Kallio, a trans man in his 50s, found a lump on his breast, which prompted him to have a mammogram and a biopsy (Buxton, 2016). The biopsy revealed that Kallio had an aggressive form of breast cancer; however, the surgeon failed to contact Kallio as he was uncomfortable with Kallio's trans identity. Kallio was only notified of his cancer diagnosis when the doctor who conducted the biopsy reached out to ask how Kallio was handling the news of his diagnosis, inaccurately assuming the surgeon had been in contact. When Kallio finally connected with the surgeon, he focused exclusively on Kallio's gender, wanting to refer him to a psychiatrist, and neglected to discuss a cancer treatment plan.

Fortunately, Kallio lived to tell their tale. Yet, Kallio's experience is more common than not. Take for example, Tyra Hunter, a Black trans woman, was in a serious car accident on her way to work (James, 2020). The emergency medical technicians who arrived abruptly stopped providing care to Tyra when they discovered she had a penis. Witnesses reported the EMTs shouted racist and transphobic slurs and that she did not receive care until an EMT supervisor arrived. Surviving this ordeal, Tyra faced similar treatment at the hospital, where doctors delayed treatment operating under the assumption she was HIV positive and refused her treatment all together (Frothingham, 2015). Unlike Kallio, Tyra did not recover and later died from her injuries—injuries that, according to her medical report, she had an 86% chance of surviving.

These horrific accounts highlight the contentious relationship trans-identified communities have with the health-care system and health-care professionals. This project utilized collective memory work (CMW) to engage six trans-identified community members in an examination of their individual health experiences to identify ways to improve health practices on university campuses and within Waterloo Region more broadly. The findings informed the content and structure for a one-day workshop aimed at providing formal trans-specific education for health and wellness educators and practitioners, broadly defined. First, we provide an overview of the literature on trans health-care

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experiences. Secondly, we articulate our methodological framework and details on executing our research study. Next, we present our analysis of our participants' memories, which collectively illustrate systemic transphobia in the health-care system. Finally, we conclude the paper by detailing how our findings both support and refute previous knowledge, along with recommendations for practice and future research.

BACKGROUND

Useful Terminology

The term 'transgender' is most commonly used as a gender identity label for individuals whose gender does not align with societal gender expectations that are based on the sex they were assigned at birth (Green & Peterson, 2006). Falling under this umbrella, there are a number of gender identities, such as trans, genderqueer, transsexual, non-binary, Two-spirit and androgynous (Green & Peterson, 2006; Lane, 2009). Trans identities can also be conceptualized as 'binary', wherein someone identifies as exclusively man or woman (e.g., trans woman or trans man), or 'non-binary', where someone identities as a combination of woman and man or neither of them (for more, see Roen, 2001). Within this article, 'trans' will be used to refer to all trans identities under the umbrella term, including non-binary identities, unless otherwise specified. Historically, transition-related health care was provided by psychiatrists, who created contemporary understandings of trans identities and criteria for diagnosing someone as trans (also referred to as gender dysphoria). This process led to what many refer to as 'gatekeeping', a system in which the trans identity is scrutinized and validated by non-trans professionals (Vipond, 2015). Trans advocates and scholars have argued that this model has overemphasized stereotypical gender norms, such as heightened femininity in trans women and masculinity in trans men (Serano, 2007). Furthermore, a person's physical appearance, including gender expression, also played a factor in whether they were granted access to transition, with trans people presumed to 'pass' (e.g., being read as cisgender) as their gender is more likely to be approved.

Trans Health Care in Ontario

As of March 1, 2016, within Ontario, trans individuals may now depend on family physicians (rather than specialized services only provided through the Gender Identity Clinic at Toronto's Centre for Addiction and Mental Health) for both general and transition-related care—including (but not limited to) hormone therapy, referrals to specialists/surgeons, and coordination with specialists/surgeons (Bauer et al., 2016; Health Services Branch, 2016). However, trans individuals who have a regular family physician continually report being told that the health-care provider did not know enough about trans-related care to provide it (Bauer et al., 2016). Therefore, many family physicians often still require their trans patients to have a referral letter from a mental health provider before administering transition-related care. Brown and colleagues (2020) examined trans people's perspectives on this process, finding that obtaining a referral letter was an infringement on their personal autonomy and was "stigmatizing, patronizing, and alienating" (p. 575).

The continued requirement for referral letters may stem from the lack of trans-related training and curricula that medical students are provided. An Ontario-based research team examined whether residents (n = 319) in family medicine, psychiatry, endocrinology, and urology, were trained to provide care for trans patients (Coutin et al., 2018). Almost all endocrinology and psychiatry (100% and 97.5%, respectively) residents agreed that trans-care fell within their medical scope; however, roughly a quarter of both residency types reported feeling competent to provide care. Similarly, 50% of urology and 71% of family medicine residents agreed trans-care was part of their medical specialty, and none of the urology, and 10% of the family medicine residents reported feeling competent. In a subsequent qualitative study, the research team interviewed medical students attending the University of Toronto. The researchers' findings highlighted that many students were not provided official training on trans-related care, and those who were exposed to such training either intentionally searched for it or happened upon it by chance (Fung et al., 2020). Another finding was a lack of clarity regarding which medical specialty was responsible for providing care, with students from one field assuming students from others were being trained.

These gaps in health-care providers' knowledge have resulted in scholars and advocates arguing for trans communities to have more agency and autonomy over their health care. The desire for greater autonomy occurs at many areas of transition, including what labels people assign themselves and physical expression of gender (Bates et al., 2020). For example, Blodgett and colleagues (2018) findings revealed having a sense of agency and autonomy in health-care settings were associated with positive health-care experiences. A sense of agency was described as knowing someone has control over their experiences, while a sense of autonomy was being recognized by their health-care providers as having the right to decide their transition. These two concepts are similar to the first two stages of Clark et al.'s (2020) decision-making model—a model depicting how trans youth navigate their identities and interactions with the health-care system. The first phase is related to self-discovery, including components such as 'develop awareness', 'deliberate', and 'research.' Within this phase, people would move beyond these three actions while they research about trans identities, incorporate this knowledge into their emerging identity, and deliberate on what their transition goals would be. The second phase is related to interactions with health-care providers and navigating the health-care system to seek out transition-related care. Within this model, trans people independently become aware, validate and create their trans identity, and only seek supports to realize their transition goals. The internalized nature of the identity development process can explain why the requirement of a referral letter is perceived as an infringement on trans patients' autonomy, as the word of an external professional is seen as more legitimate than an individual's sense of identity.

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Trans-specific Barriers

Despite recent developments in trans rights across Canada, current population health surveys (e.g., the Canadian Community Health Survey) and census forms have historically failed to acknowledge the diversity within trans and gender-diverse populations by limiting respondents' ability to indicate identities beyond male or female (Giblon & Bauer, 2017). As a result, researchers have been unable to accurately estimate the number of trans individuals living in Canada (i.e., rough estimates of approximately 0.5% of the Canadian population); and subsequently, lack the ability to assess the health inequities experienced by trans individuals (Giblon & Bauer, 2017). While unable to fully assess the magnitude of health-care inequity experienced by trans individuals in Canada, previous research on the health of trans Canadians has revealed that the trans community is consistently underserved in both primary and emergency health-care settings—citing barriers such as lacking knowledgeable care providers, refusal of access to health care, and/or care provider refusal to approve hormone therapy and/or surgeries (Bauer et al., 2009; Bauer et al., 2014; Graham et al., 2011; Snelgrove et al., 2012).

Furthermore, when broaching such topics, approximately 40% reported experiencing discriminatory behaviour (i.e., refusal to examine specific body parts and using insulting language/terminology) on at least one occasion during an interaction with their family doctor (Bauer et al., 2009; Bauer & Scheim, 2015). Additionally, for trans individuals who have accessed—or attempted to access—emergency health-care services in Ontario, one in 10 reported they had been refused care or had care prematurely terminated when in an emergency room; while one-quarter had been belittled or demeaned by an emergency care provider. As a result, approximately half of respondents stated that they were not comfortable discussing trans-related topics in primary and emergency health-care settings (Bauer & Scheim, 2015).

These past experiences of discrimination and/or the fear of future instances of such discrimination may result in trans individuals avoiding any encounters with the health-care system. For example, Bauer and Scheim (2015) reported that health-care avoidance is highest amongst trans individuals, such that, 21% of trans individuals have avoided the emergency department despite needing immediate care. Further compounding the complexity of trans health-care needs, trans individuals may potentially have higher needs for some health-care services. As indicated by disproportionately high levels of depression (e.g., > 50% had depressive symptoms consistent with clinical depression) and suicidality (e.g., 43% had a history of attempting suicide), as well as an elevated risk for HIV and other sexually transmitted infections (Bauer & Scheim, 2015; Bauer et al., 2016). Stemming directly out of the barriers to comprehensive health care for trans individuals highlighted herein, 1 in 3 trans individuals living in Ontario report unmet health needs; while also experiencing high percentages of poor health care quality and availability (Giblon & Bauer, 2017). Therefore, these lived (and anticipated) experiences of discrimination, and subsequent avoidance of health care, create the potential for life-or-death consequences for trans individuals (Bauer & Scheim, 2015; Grant et al., 2010; Socías et al., 2014).

METHODOLOGY: COLLECTIVE MEMORY WORK

Using the qualitative participatory action methodology, CMW, our project sought to explore trans community members experiences in relation to their health care. As we prepare for a shift in provincial educational and health-care policy reform that prioritizes support for health-care providers in creating trans-inclusive primary care environments where comprehensive services that address trans health needs are provided (Bauer et al., 2016), we need data on both the positive and negative instances encountered by this population. Examining memories both of emotional valences provides insights into how trans patients are impacted by health-care providers, both affirming and discriminatory experiences.

Collective memory work, as a methodology, is particularly useful in collecting this data. Specifically, CMW allows participants (as co-researchers) to recall, examine, and analyze their memories and experiences, both positive and negative, within a broader cultural context to see how their individual experiences link to collective, shared experiences of similar and/or different groups (Haug,1992; Johnson, 2018). Frigga Haug's (1987, 1992, 1998) formulation of CMW follows from the paradox that experience and identity are collectively rendered, and yet there remain opportunities for individuals to maneuver within social boundaries. In its initial incarnation, Haug conceived CMW as a feminist methodology that would create spaces for women to collectively explore identity by holding ideologies of misogyny and heteronormativity up for scrutiny. Despite its intention to address the experiences of women, we nonetheless contend that CMW is useful and applicable to the experiences of any individual who attempts to come to grips with the role of hegemonic ideologies (including cisnormative ones) in the experience of daily life (Johnson, 2018).

Despite its broadened scope, CMW retains its emancipatory ethos with regards to the relationship of researchers and participants. In contrast to the potentially exploitative relations of conventional research, CMW conceives of participants as being collaborators in the conduct of research. Consequently, the power between the researchers and participants is minimized and instead are conceived of as co-researchers, assisting with generating data, conducting analysis, assisting in the representation of data and sometimes assisting with interventions.

Our Inquiry Team

In this CMW project, our "trained" research team was comprised of a senior faculty member, two Ph.D. students and a local trans mental health provider. All research team members identify as white, between the ages of 30–48 years old, and identify as non-binary (1) woman (1) and men (2). Adding an appropriate layer of identity complexity, two of the team members identify as part of the trans community and two identify as cisgender who are striving to be better allies. Once the primary research team

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was in place, we worked to secure ethics approval, flush out our writing prompts and start recruitment.

In an effort to build the remainder of our inquiry team, we set out to identify local trans participants in our community who had lived experience-related health care in the region. Keeping our inquiry group manageable, as dictated by CMW, we sought six additional participants. Our recruitment efforts included purposive and snowball sampling techniques (Johnson & Parry, 2015), targeting popular LGBTQ2S+ affirming organizations to share information about the goals of our study and direct interested parties to contact the researchers via email. Our initial efforts resulted in over 15 individuals willing to participate. Of those, we identified six who could meet the obligations (meeting time and commitment to writing stories) of participation. These six were 17–30 years of age, with five participants identifying as white, and one as South Asian. In terms of gender identification, we added two trans women, one trans man, and three non-binary individuals/participants to round out the inquiry team. Our mental health counsellor facilitated and participated in both the data generation and analysis.

Simultaneous Data Generation and Analysis

Once participants consented to participate, the facilitator asked each person to write about two memories in third person (using pseudonyms) in preparation for a scheduled focus group session. The first story detailed a significant memory related to a health-care experience that affirmed the participants gender identity, and the second story details a less positive, or negative, one. Each story was one or two pages maximum and written in a descriptive fashion. Participants were able to choose any prior memory; therefore, the memories were shared from various points in participants' lives. The next stage of CMW had our participants engage in a process of collectively constructing social understandings of the memories. This collective theorizing occurs in a focus group setting where participants engage in processes of exploration and discussion while acknowledging that meanings will often be contested, and that multiple meanings are possible. During the four-hour focus group, the facilitator directed the participants to explore the substance and the structure of each story through the following prompts: 'What is this story about and what does it mean?', 'What is the author's perspective on what it means to be trans?', and 'What does it mean to experience health care in the story?'

This process includes a collective analysis process of underlining verbs, which represent the action of the story, and circling adjectives, which represent the emotions of the narrator and others. As participants engaged in this process of analyzing their stories, they came to collective agreements about the meaning of their stories, the intentions of the author, and the intentions of others. Next, the facilitator asked the participants, "How do these groups of stories of health care inform our understandings of trans experiences? What are the implications of these messages, both individually and structurally?". This prompt allowed the participants to consider all of the stories together to identify commonalities and disparities, and to identify the ways in which health-care practices in the Waterloo Region might be improved. In total, our data set included 12 stories and a transcript of over four hours of focus group dialogue.

The focus group recording was transcribed verbatim and was thematically analyzed by a trans doctoral student who had experience with analyzing qualitative data and working with trans-specific research. The data analyst familiarized themselves with the participants' memories, and then subsequently read the focus group transcript in full. Following the stages of thematic analysis (Braun & Clark, 2006), meaningful elements were initially identified as codes, with similar codes being sorted and compiled into larger themes. These themes were refined and defined by the analyst, drawing upon their lived experience and expertise to identify the most salient themes in the data set.

While the focus group transcript was the main source of data, excerpts from the participants' memories have been provided in italics when each theme is introduced in the findings section. These excerpts are included to provide the reader with a brief snapshot of the memories written by the participants.

FINDINGS

We have identified three themes, including: 1) unrecognized power of health-care personnel and institutions; 2) lack of accountability in quality, and 3) the emotional toll of interaction with personnel as stewards of their institutions. These three themes were explored within an overarching analogy, what the participants referred as being in an "abusive relationship with the health-care system." The participants used this analogy throughout the entire focus group to help them contextualize their experiences, and more specifically the emotional toll of interactions within the health-care system. This analogy is illustrated in the following exchange:

Dahlia: *It's almost like you're walking into a ... You're in an abusive relationship with someone and you do not know whether it is going to be bad or not. But whether you still want to, you are just stuck there. It's like being stuck in an abusive relationship.*

Ash: *Unfortunately, we are all in an abusive relationship with the health-care system and we can't escape it until the day we die.*

Jason: *And you're just like hoping for the best. Like is the health-care system in a good mood today? Did I say the right thing?*

Sarah: *But actually though. That's a very good analogy sometimes.*

What is obvious is that trans people expect negative outcomes, but are faced with no other options; where options do exist, they are resource-exhausted alternatives or at an untravellable distance. With frustration in her voice, Dahlia explained how trans people are 'stuck' relying on health-care providers for necessary care. Secondly, it demonstrates the victim-blaming or internalizing of these negative experiences. As Jason asks, 'Did I say the right thing?' implying that trans people are self-monitoring what

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they say or do not say to their health-care providers. Lastly, it is evident from this exchange that these interactions have a significant emotional impact on the participants. Although this overarching sentiment is enough to move us to action, in an effort to explicate on this "abusive" narrative, in the following sections we will discuss these themes, utilizing both the memories and focus group discussion/analysis of the memories, to substantiate our interpretations.

Unrecognized Power of Health-Care Providers and Institutions

As soon as Knox came out as trans, their parents booked an appointment with the gender clinic. Once there, Knox met with a counselor and the entire appointment was more an hour of Knox trying to prove their "transness." At this appointment, another appointment was booked with a doctor to discuss medical transition-related options. This was scheduled for four months into the future. A month before the appointment with the doctor, the clinic pushed the appointment another two months. Finally, time comes around to meet the doctor. Three days before the appointment, Knox gets a letter saying the appointment has been postponed indefinitely. Knox starts calling the clinic to try and rebook, but they never answer the phone. Finally, they get an appointment. This has been a year since the first time they called to book an appointment. The doctor tells Knox that it's too late to start hormone blockers now and that the clinic can no longer provide treatment, even though they aren't going to age out for another eight months.

The main barrier to accessing health care discussed within the focus group was the power the health-care institutions and, thus, medical professionals had over transgender people. The power exerted by medical professionals within these collective memories included refusing care, deciding whether a person is 'trans enough' to receive transition-related treatment, and claimed ownership of medical files, which allowed medical professions to dictate which gender was listed. We explore two subthemes, 'gatekeeping', and 'bearing the burden while wrestling for control'.

Gatekeeping

This power dynamic was especially salient during the discussions between Knox and Ash's stories. Knox focused their negative memory on the experiences they had accessing a gender clinic as a youth. The professionals at the clinic had extensive requirements, such as several counselling appointments to confirm Knox's 'transness', which effectively delayed Knox's ability to access transition-related treatment until they 'aged out' of the program. Conversely, their positive experience centered on their appointment with an endocrinologist who answered their questions and prescribed Knox hormone blockers, providing them more time to make a decision whether to also start hormone replacement therapy (HRT). Ash described ruminating over the decision whether to start HRT, citing uncertainty with possible side effects. Their desire for HRT was made salient when they missed an opportunity, resulting in at least a six-month wait for another opportunity. Luckily, they were able to access a clinic offering informed consent-based HRT in the United States. The American endocrinologist patiently answered all of Ash's questions, providing reassurance that Ash was in control of their transition and what transition meant for them. While discussing these two experiences, the participants related these power dynamics of the health-care system to the historical origins of trans health care:

Jason: *And put the two together, the contradiction is ridiculous. This is a gender clinic. They should have helped you...So even trans-positive doctors can fail people, but as long as the doctor's trying to do their best it's very helpful, is what I'm kinda understanding.*

Dahlia: *It's also, according to the broader context, historically, the people who have worked with trans people, they were the ones who were most transphobic. They were the ones who were pro-gatekeeping and kinda had a system in place to push trans people away, right? So, it's kind of ironic if you look at the history.*

Denver: *But more than that, whether doctors have worked with trans patients or not, there seem to be two different philosophies of how do doctors feel about the care that they give to their patients? Do patients have the agency to make decisions for themselves? Do they know what's best for them? Or does the doctor know what's best?*

The participants further highlighted the inherent power dynamics between health-care providers and their patients in the following exchange:

Sarah: *I have to word it evasive, like double underlined at this point. It's like what is this question of who gets to define your identity and your own care. In Ash's positive story it was very much they got to define what their own transition and what their own care meant to them. In Knox's case it very much feels like the doctor is trying to say "Well we have power over what your transition's going to look like. Whether you are trans enough." And the fact that I need to say that phrase is ridiculous.*

Dahlia: *Yeah. It's almost like the norm and is justified and it's more valid and if you're not [trans enough], then the onus is on you to prove to us so that we can give you the care that you need. So clearly in that dynamic, it's clearly one who has more power over the other. [emphasis in original]*

Within these reflections, it is clear that health-care providers have the power to assist or deny patients' autonomy to decide how they want to transition. As Dahlia mentioned, this power is rooted in historical psychology discussions of transgender identities and dysphoria. Historically, psychiatrists had the power and authority to create the criteria categorizing someone as transgender, and thus could choose who transitioned or not (for more, see Vipond, 2015). These criteria were rooted in transphobic ideas and created unrealistic standards of what

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a trans identity looked, leading many trans people to perform their gender in specific ways to meet psychiatrists' definition of gender dysphoria. These outcomes have been referred to as 'transnormativity', which refers to how trans identities are evaluated against medicalized understandings of gender that prioritize and categorize cisgender identities as the 'norm' (Bradford & Syed, 2019; Vipond, 2015). This gatekeeping process is the origins of the phrase 'trans enough', specifically whether someone is 'trans enough' for health-care providers to allow to transition. This model has been advocated to be removed and replaced with consent-based models. However, as seen in Ash's Knox's memories, clinics operating within this model vary quite considerably.

Bearing the Burden While Wrestling for Control

The authority of health-care providers is shown in conversations about medical files. During Ash's negative memory, they recounted a time when they overheard a doctor murmuring under their breath while taking notes. The doctor was using the wrong pronouns for Ash, which prompted Ash to disclose their nonbinary identity and correct the pronouns used in their medical notes. The doctor responded by saying the medical notes are for their use and they are going to keep taking notes in this manner as this has always worked for them. After the appointment, Ash filed a complaint against the doctor and was told the doctor would be asked to redo sensitivity training. Beyond that, there were no other options for the clinic to pursue.

Denver: *I think there's also that power dynamic that we mentioned earlier that this doctor feels like, "Well these are my notes for myself. I'm called by to do whatever I wanna do for that and you don't really have a say." And then the fact that they're making the doctor redo the sensitivity training but clearly it didn't work in the first place. Why do you think it's gonna work if you're repeating the exact same thing?...*

Jason: *Do you think that the doctor thinks that they behaved in a way that was okay? Because even in how they respond, of like, "Look I understand ..."*

Sam: *Or "I hear your concerns, I acknowledge"—The doctor doesn't care.*

Dahlia: *And just like the contradiction, kind of gets highlighted here, because he says, "I acknowledge, and respect ..." But clearly he doesn't know what he needs to do in terms of action, to do the same thing. So, acknowledge and respect, he does not.*

Sarah had a similar experience in her negative memory. When she accessed a clinic, she had the option to indicate her chosen name and pronouns. However, her deadname was called in the waiting room by a nurse and also utilized by the doctor she saw. A 'deadname' refers to someone's given name or legal name. This specific term was coined because this was the name used for trans people's obituaries (Davis, in press). Subsequently, the use of one's deadname can be perceived as a harmful dismissal of one's identity (for more, see DeJong et al., 2021). When Sarah corrected the doctor, she was told she should have informed the intake receptionist so this error would not occur. The doctor failed to apologize when Sarah pointed to her name and pronouns highlighted on her chart. The implications of Sarah's memory were highlighted by the participants as the doctor's authority to shift responsibility, and thus blame, from the doctor to the patient.

Ash: *I have the words 'forced' and 'active' underlined. It brings us back to this question of who has the burden in terms of health care. Where is it up to the patient to take their own health care into control, and where is it the doctor's responsibility to care for their patient? And she did! I think that's something really important.*

Dahlia: *Yeah, no, this is the typical attitude doctors have, right? Never their fault for anything, it's just like, "Yeah, intake or receptionist, or somebody else must've...It shouldn't be up to me to say sorry. Somebody else's job is to say sorry or apologize to you." … It's almost like, yeah, shifting the blame.*

The discussion of this experience illustrates two main points. Firstly, the participants have been told, either subtly or directly, that they are responsible for ensuring their own care. As Ash implies, the point at which the health-care provider should ensure quality care and the extent to which patients need to advocate for their care is blurred. Despite Sarah following the procedure to indicate her name and pronouns, the two health-care providers did not check her chart. Secondly, there can be harmful effects of these interactions. In Sarah's memory, she explains that she did not want to see another health-care provider for a few months afterwards.

Denver: *And, also, it says, "Thankfully, their condition cleared up on its own," and that's serious, that's really... To think about that is very awful and concerning, because you go for something completely unrelated, and you come out feeling awful about yourself and feeling like you can't get care that you need.*

Despite Ash filing a complaint against the doctor, they were told that the only repercussions for the doctor was to ask them to redo sensitivity. The lack of further action is connected to the next subtheme, the lack of accountability in the delivery of quality health care.

Lack of Accountability in Quality Care

When he went through a serious injury that required going into the hospital, it hadn't crossed his mind until he was asked for his health card that things could potentially go wrong. Remembering that he still hadn't updated the sex designation … he was slightly nervous. Everybody that he recalled interacting with gendered him correctly, even though his hospital band branded him with a burning 'F'. It wasn't even a major accomplishment of the health-care workers he interacted with to do this, but it was something that made him feel like it would be somewhat safe to be here. It was small interactions that people made to have him feel this positively...People calling him "young man".

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He wasn't particularly androgynous, though he knew there were some signs that he was trans that could tip off the staff and put him in risk. Knowing that these health-care professionals have the power over his well being was an intimidating thought, especially because he knew that people who were anti-trans could get particularly vicious. The fact that nobody asked him about the discrepancy between his documentation and how people perceived him was positive for him, but he knew that if he were a different person, at a different time, the interactions might have been more harmful, rather than helpful.

Connected to health-care institutions' power over transgender peoples' care was the notion that there is a significant lack of accountability of the care that transgender people do receive. When participants sought out care from medical professionals, they were often misgendered, denied care, or had otherwise negative experiences. Denver states:

They don't know anything when we're like, "Oh I need trans health care though." Suddenly they stop knowing things, when you're like, "Hello I'd like health care, because I'm trans, and I have health-care needs related to that." And then they're like, "Sorry I have no medical knowledge anymore, it's disappeared! Don't know what happened!'

The frequency of negative interactions with accessing health care has impacted how the participants conceptualize their expectations for the quality of care they receive. When commenting on Sarah's negative memory, Ash observed:

There's this recurring theme occurring throughout all the stories that the bar we set as trans people for care that we expect for us from the medical system is lower. Other people's 'normal' is our 'good' or 'fantastic' depending on your scale of experiences. I mean, even the end of the second paragraph, "Although this error did have a significant effect on Sarah, the appointment would've been acceptable if what happened next did not occur. Like, no! Even what happened in the first two paragraphs should not be acceptable!

It is important to note that the positive memories analyzed by the participants also contain similar sentiments. For example, Sarah described a very rewarding counselling session, which allowed her to destress, and Denver's positive story focused on his relief that he did not experience transphobia when accessing an emergency department. As previously discussed, Knox's and Ash's positive experiences involved receiving a prescription for hormones after experiencing barriers to care previously. When speaking to Denver's positive story, the participants made the following realization:

Jason: *So, it like when I read this, it sounds like first of all, this person's hurt, but it also to me sounds like the fear was already there. Like, is this going to turn out badly for me before anyone ever said anything. Right? Because of maybe transphobia existing and then the other people like essentially just did their job.*

Dahlia: *But all of this being a positive story but still conveys that sense that people are worried, and everyone worries that something bad or something negative can happen because something negative does happen most of the times…you would still carry that burden of the negative thought and every time you interact you would worry about it...*

Ash: *But it says something too that it's a positive experience when something doesn't go wrong in the first place. When health-care providers do do their job and do treat trans people with respect. [emphasis in original]*

Furthermore, Jason says:

So, remembering that he still hadn't updated the sex designation on his health card because all the additional steps required, he was slightly nervous. So, a part of me wonders if like Denver wasn't in an emergency situation and if they were like a bit unwell, would they ... the story is kind of set up like they only did it 'cause they had to, and if they were just a little bit sick maybe they just would have avoided health care and pushed through.

These discussions also highlight a very concerning consequence of systemic transphobia in the health-care system, specifically that some would avoid accessing care. Sarah ends her negative memory with, "*Overall, the experience left Sarah feeling ignored and dysphoric. She did not return to health services for several months afterwards and thankfully her condition cleared up on its own.*" In Sarah's case, the medical personnel was not only overtly transphobic, but also did not address Sarah's medical concern.

The participants also discussed how trans people could fall through the cracks or be referred to other professionals. When Knox was experiencing delays at the gender clinic, they sought help with their family doctor, who denied their request and redirected Knox back to the gender clinic. The participants speculated that health-care providers' tendencies to refer patients to others was to shift responsibility and avoid repercussions. For example, Jason explains how health-care providers require social workers to write letters of readiness for trans patients:

So [social workers are] often asked to write letters of support for people to access the health care they need. And there's lots of reasons for it, but one of the reasons is that doctors want to share the ethical and legal responsibility of providing trans health care, in case the person comes back and says, "I changed my mind, and you did this wrong." Social workers don't write letters for people who have a broken leg, and they're choosing one, like pins versus a cast. There's all sorts of very convoluted, transphobic fears that end up ... And that's not the only reason, but that is one of them as far as I can suss out. And that's not written anywhere on a paper, but that's sort what I've come up with.

The participants extend this argument to highlight how health-care providers are operating within a seemingly fear-based approach. As Dahlia explains, the fear of negative consequences prevents them from feeling confident in their care provision. The participants discuss whether health-care providers have been sued by trans patients, specifically those who have regretted receiving transition-related services. None of the participants knew any stories of this occurring, although Denver recounted

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a story in which a health-care provider was being sued from a patient's parents, who disagreed with their child being able to access HRT. Dahlia summarized this conversation by saying:

> *That kind of talks about that consequence, right? So, if doctors have taken trans patients and prescribed hormones and provided the health care, and the .01% chance at they get sued for... by the parents or by the patient, or whoever. It's almost like they know that they would have a consequence of that. There would be a negative repercussion of that. But on the other hand, 99.99% percent of the cases where it's not happening and they're not providing that health care... There isn't a consequence of not providing that health care, right?... For some doctors, it's almost like they value that negative consequence and the repercussions so much that they're willing to compromise on very basic medical ethics, which is to always care for the good of the patient. So, it's... that's a choice they're willing to make.*

This exchange highlights the complexity of providing trans health care, especially to minors who may not have supportive parents. The current system, which is perceived as lacking clarity regarding who is responsible for trans-specific care, allows for health-care providers to prioritize their risk for repercussions at the expense of their trans patient. Within this quote, there is an implication that trans health care is deprioritized, resulting in health-care providers who do provide care to their patients experiencing potentially more repercussions than those who deny their trans patients care.

Being denied care was often attributed to the lack of knowledge on trans health care; however, participants argued medical professionals used this tactic explicitly to avoid providing care.

> *Dahlia: Not knowing about [trans health care] is an option for the doctor, right? So, if you just go in for a flu, the doctor will be like, "I don't know about flu, sorry." That's not something a medical practitioner can say, right? Whereas, for trans health care which is the bare basic thing which every trans person who are on hormones or who need medical care needs, that's an option which doctors can have. And most doctors [can say], "I don't know." Almost like you're not even human, right? It's like, "I don't know how to treat anyone who's not human, sorry."*
>
> *Ash: What is this thing?*
>
> *Knox: Oh, sorry, I'm not a vet.*
>
> *Dahlia: A doctor will be terribly embarrassed to say they don't know how to treat the flu, but they feel confident, it's 100% okay to say, "I don't know how to treat a trans person."*

Within this exchange, the participants feel that doctors often equate trans patients as 'things', and 'not human'. These terms suggest that trans patients who are denied care feel dehumanized, receiving the message that trans patients are as alien to doctors as treating an animal would be. This exchange also reinforces the fact that there is no medical specialist or authority that is responsible for providing trans health care.

Emotional Toll of Interaction with Health Care

> *When he met up with the doctor he was scheduled with and told her what he came for, she was honest and said she didn't know how to help him. She decided to send him a referral to [another doctor] as she said this doctor was the only one on campus that was knowledgeable on trans health care, and he was thankful for this but also frustrated. He'd gone around in circles just to find that it would have been easier if I had just spoke up and dealt with whatever shame he felt. He takes a lot of the blame on this event himself, but there was absolutely a way it could have gone better if he'd been given the impression that he wouldn't be treated the way he feared he would.*

The final theme is the impact health-care interactions have on trans people's wellbeing, especially as they play a key role in the transition journey. The emotional outcomes of these memories were very salient. As previously discussed, health-care providers refusal and dismissal dehumanized their patients. Denver's negative memory provides an excellent illustration of the emotional effect that interactions with health care can have on trans people. Denver accessed his university's health clinic to speak with a specific trans-positive doctor to request a prescription for hormones. However, he was told that the doctor was not accepting new patients and was scheduled an appointment with another doctor. The second doctor stated she was not knowledgeable enough about HRT and referred him to the first doctor. In his retelling, the discrimination he was anticipating was very evident. Sarah describes:

> *Well, it seems to be about Denver's struggle with, you know, asking for hormone therapy and seems to, as far as the meaning goes, it really seems like the central theme is fear. Like all over the place. The third to last word is 'fear'. You know? Seemed like at every step he was just very afraid... which is extremely understandable, you know?*

Denver internalizes this fear, which manifests as feelings of shame as he takes the responsibility and blame for the frustrations he felt. It is interesting to note that his main source of shame is not advocating enough to see the trans-positive doctor. Unlike Knox, Denver was not systematically barred from receiving trans-related care; rather, he was referred to a doctor guaranteed to help him. The participants unpack how Denver discusses his feelings:

> *Sarah: It also seemed like the experience, like, had a fairly significant psychological impact on Denver. Cause I read phrases like, "He froze up, he chickened out" or like, especially for someone who is identifying as masculine, like, those phrases tell me that he still is beating himself up over this. As he's writing this paper, he's still beating himself up.*
>
> *Ash: There also seemed to be a much more, you know, intimate connection with this story than positive one. Noticed it slips into the first person.*
>
> *Sarah: Exactly, yeah, exactly. "If I had just spoke up." Yeah, he was emotional. That phrase, "It'd be easier if I'd just*

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spoke up." This is him actively beating himself up and he's so concerned with beating himself up he can't even talk in the third person.

In Denver's memory, the burden to seek out the right doctor, which would have required him to research trans-positive doctors in Waterloo region, was placed on Denver. It is important to highlight that Denver was very impacted by this experience despite being given a referral. The other participants, especially Knox, experienced significantly more barriers to receiving transition-related care. The participants discuss the ramifications of these experiences in the following exchange:

Sarah: *I mean the implication is that the medical community, even though they're attempting very, very hard at this point to include trans people in their health care, it really seems that they have their own internalized transphobia. [Like in] Knox's case - Just being flat out refused in the end. That is, boom, very transphobic to me. You can shift people around, and claim, "I don't have time, I don't have time," but when the person is sitting right in front of you and you say, "No,"*

Ash: *And that their actions or inactions can affect us in—I mean, doctor's might think, "Oops, this is a mistake," or they might shrug it off, or they might think that it's not their problem. But it affects us, as trans people, in very visceral ways that people aren't going to recognize because people don't want to take blame for their negative actions.*

Ash explains that health-care providers can have a larger impact on trans patients' wellbeing than they recognize. Within this quote, Ash says 'inactions', referring to health-care providers not providing care, or small mistakes that seemingly can be 'shrugged off'. Ash theorizes that health-care providers are not going to recognize the impact they have, because doing so may also require recognizing their responsibility or blame.

Whether trans people advocate for themselves is a balance between whether to prioritize their feelings of safety, their wellbeing, and making themselves vulnerable to experiencing transphobia from health-care providers. Denver explains, "There's also this idea that we're not allowed to react", rather, trans patients have to 'passively take' the health care they do receive because they may not know how else to navigate the health-care system. If trans patients do speak up, they can be labelled as aggressive. Denver explains:

I've called out doctors for using the wrong name, wrong pronouns, and I've been told I'm very aggressive, or "Stop being so angry." After all that we've been through to try to get the care that we need, we're going to reach our breaking point.

Furthermore, the participants discussed having to be mindful during their interactions with health-care providers for fear of having their health care revoked.

Ash: *And there's this thread to that, what if we say the wrong thing? Our communication's going to be twisted against us. If I say the wrong thing, is my doctor just going to suddenly refuse care to me?*

Jason: *Take my medication away?*

Ash: *Yeah. Because the medical system is one big gatekeeper between us and what we need as trans people. Our wellbeing ends up, and whether we end up having agency over our health care ends up in the hands of the doctors that treat us.*

As previously discussed, the gatekeeping process was to regulate who was granted the opportunity to transition. The participants explain how health-care providers may still operate within that approach, resulting in the participants feeling trepidation when interacting with health-care providers. They describe feeling like they are being denied their agency over their health care, afraid to say the wrong thing or react negatively in case they experience negative repercussions. As Ash says, the wellbeing of trans people is in the hands of health-care providers that also can grant or deny trans people's agency. It is important to note that not all trans people desire a medical transition; however, those who do, require the assistance of a health-care provider. Within the memories analyzed, this relationship seems to have two possible paths: one is the trans patient feels dehumanized, referred to others as in Denver and Knox's case, or a pivotal character in one's emotional transformation, as in Sarah's case. When summarizing the overarching themes of the focus group, Jason makes the following distinction:

We're talking about how individuals internalize transphobia to the point where they're happy with bare minimum health-care services, and then, structurally, doctors and health-care services often get passes for behaving like you don't have to behave in an ethically responsible way. Because, trans people, you don't have to answer the phone, you don't have to call back, you can just pass it on to another doctor, which you wouldn't have with other issues. And then, if a doctor does go out of their way, they're like heroes because they went above and beyond, which most doctors do all the time.

Jason eloquently highlights systemic transphobia in the health-care system and its impact on trans people. Their quote implies a certain powerlessness that trans patients can feel as the health-care system has not been created to address their needs. This powerlessness was also evident in how Sarah's reflection of her involvement in the focus group. She says, "*I also kinda want to note, even though it was very draining, I don't feel like I learned very much. There were some things that maybe became clearer, but I have talked about all these things before, multiple times with people. None of this is new.*" In this quote, Sarah is referring to the focus group discussion, specifically that the challenges and successes discussed were not new and have been discussed within/between trans communities for a long time now.

When Knox was ready to start hormones on top of the Lupron, the doctor was on board with whenever they wanted to start and whatever dose they wanted to start on. Knox was able to actually discuss their fears with starting hormones without worrying that the doctor would take it away, as the local gender clinic was

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known to do. The endo has laid out all the options about long-term care and is very open to discussing dose changes. Knox was able to choose the day they wanted to start hormones and the endo even stayed late when they were fully booked on that day.

DISCUSSION

Our findings highlight the urgent demand in addressing systemic transphobia in the health-care system. The collective memories of our participants showcased how trans people are denied care, referred around to different doctors, dehumanized in interactions with health-care providers and feel as though their agency in their care is being denied. Our findings are consistent with previous research demonstrating that trans people have unmet health-care needs, despite having access to primary health-care providers. The Trans PULSE research team found that trans Ontarians have significantly higher rates of unmet health-care needs compared to cisgender people (Bauer et al., 2015). When examining trans communities across Canada, Trans PULSE found that roughly 45% of trans Canadians have an unmet health-care need in the previous year, despite 81% having a primary health-care provider (Trans PULSE, 2020). Furthermore, research from the Outlook Study found that avoidance of emergency departments is related to transition status or stage of transition with those who had started or completed their transition more likely to avoid emergency departments (Thompson-Blum et al., 2021). Similarly, Denver was expecting to experience transphobia while in the emergency room because the gender marker on his health card was not updated. Fortunately, his fears were not realized, but the experiences of the other participants, who were at various stages of transition, highlight that they easily could have been.

Our findings lend support to Clark et al.'s (2020) decision-making model. The transition-related memories analyzed highlight that trans people ruminate and deliberate their identity before seeking support. Our findings illustrate how seeking support during this time can be particularly vulnerable, as evidence by Denver who internalized his negative experiences. Trans PUSLE researchers found that trans people are significantly more likely to report depression and suicidal thoughts and behaviours if they plan to transition but have not begun (Bauer et al., 2013). Since suicidality is heightened during this process, it is particularly concerning that our participants described being denied care, especially as overtly as Knox experienced. Health-care providers denying care to trans people during this time are potentially decreasing their quality of life, potentially to fatal levels.

A unique contribution of our study is our participants' analysis that specifically contextualizing trans people experiences as rooted within systemic transphobic in the health-care system. Specifically, trans-related care was created and continues to operate within processes designed to empower health-care providers over trans people, especially as health-care providers are the gatekeepers between transition-related care and those who need it. Despite health-care providers being granted the responsibility to regulate transition-related care, they are not provided adequate training. This model prioritizes health-care providers' 'status quo,' as our participants referred to it, and comfort levels. Based on our participants' experiences, trans health care is de-prioritized, resulting in no accountability to ensure health-care providers are providing care to their patients. Ash filed a complaint against a doctor denying to use their correct pronouns and was told that all that could be done was requiring the doctor to redo the sensitivity training. However, as previous research has shown, the training provided to medical students may not include trans topics (Coutin et al., 2018; Fung et al., 2020). Therefore, it seems that, with perhaps the exception of egregious acts, there is no governing body charged with ensuring the quality of care provided by health-care professionals.

The consistency in which literature has demonstrated the Canadian health-care system cannot adequately meet the needs of trans communities suggests a larger, societal problem. Drawing from human rights frameworks, such as the capabilities approach, situates the experiences of our participants as a human rights violation. The capabilities approach is a framework that defines human rights not by the laws and policies mandating rights to citizens, but by citizens' abilities to utilize resources and services (Nussbaum, 2003; Sen, 1990). Mapping this framework onto our findings, it is apparent that our participants' do not have the capability to enact their right to health care and bodily health because of the barriers they experienced in accessing health care. Within our participants' experiences and discussions, they revealed that these rights were being denied for the comfort of health-care providers, their habitual ways of taking notes. Within Knox's case, it is not clear what the health-care providers at the gender clinic prioritized over Knox's rights to health care.

Furthermore, the participants theorize the reasons why some health-care providers deny providing transition-related care or rely on referral letters. Jason speculated that health-care providers specifically require referral letters from a mental health provider to share the ethical and legal responsibilities, which could minimize potential repercussions faced by the health-care provider. This requirement shifts responsibilities onto the trans patient, burdening them with researching transition-related care options, trans-friendly health-care providers and how to navigate the health care system. Research has also overwhelmingly shown that trans patients have to educate health care providers as well. The OutLook Study research team found that 75% of their trans sample had to provide trans-related education to four or more medical specialists (Davis et al., 2018).

The findings from our study highlight that the transphobia trans patients experience is systemic. Spade (2015) argues that critical trans rights become limited and restricted when examining them through an administrative or discriminatory lens. Rather, he argues that trans rights reform will need to address the colonial, patriarchal, and ableist context that legislation is created within. Specifically, that while health-care providers enact transphobic remarks during one-on-one interactions with their patients, they operate within a health-care system that was not designed to accommodate trans people. Connected

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to our themes, systemic transphobia in the health care system needs to be addressed by recognizing and questioning the power health-care providers have, increasing patients' autonomy/agency by removing barriers to transition-related care, and make trans health care every relevant health-care provider's responsibility.

RECOMMENDATIONS

Our findings reveal that trans health care needs to be reframed as a basic right; specifically, the right to access inclusive spaces and equitable health-care services (CMA, 2015). Denying trans patients their rights to access health care should be recognized as a serious act, one which could put trans patients at heightened levels of suicidality (Bauer et al., 2015). Furthermore, health-care providers should be not considered the experts on trans identities, allowing for trans patients to exercise greater agency and autonomy over their transition process. This recommendation is not to suggest that the medical expertise of health-care providers is not essential, rather, health-care providers should be not the authority for what criteria defines being trans, and thus who can transition. This is especially true for trans communities from non-Western communities as they may have different conceptualizations of gender and may experience greater barriers as they are held to Western standards (for more, see Davis, in press).

Our findings made apparent health-care providers' ability to not only deny care to trans patients, but also to remain unqualified and unknowledgeable to treat trans patients. Consistent with previous research, our participants discussed how health-care providers 'feel confident to say, 'I don't know how to treat a trans person.'" Therefore, trans-specific curricula need to be prioritized and included in medical schools to ensure future health-care providers feel competent to work with trans patients.

The final recommendation is to increase the quality of care that trans patients receive. As our findings indicate, trans patients experience heightened fear when interacting with health-care providers—fear that their words would be used against them to justify ceasing medication and overall care. Three of the four memories included situations where the participants wanted to address and rectify the behaviours of their health-care providers but were unable to.

LIMITATIONS OF STUDY

Our study had a few limitations. Our sample was comprised of students who were predominantly white and with little range in their ages (e.g., 17–30). These factors could potentially limit the transferability of our findings. Furthermore, other demographic information, such as socioeconomic status, stage of transition, and how participants conceptualized their transition, were not examined within the collective memories. Understanding this demographic information could have provided more context when analyzing the participants' perceptions of their interactions and how these varying identity categories could have impacted dynamics in the patient-doctor relationship.

CONCLUSION

The overarching analogy used by our participants is that trans people are in an abusive relationship with the health-care system. Complete within this analogy are analysis about the unrecognized power health-care providers and institutions have, the lack of accountability in quality of trans health care, and the emotional toll that these interactions have on trans patients. Utilizing a CMW framework allowed for the individual experiences of our participants' memories to be connected to build an understanding of systemic factors. This study of collective memories of these trans individuals have illustrated the systemic nature of transphobia in the health-care system.

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REFERENCES

Bates, A., Hobman, T., & Bell, B. T. (2020). "Let me do what I please with it... don't decide my identity for me": LGBTQ+ youth experiences of social media in narrative identity development. *Journal of Adolescent Research*, *35*(1), 51–83. https://doi.org/10.1177/0743558419884700.

Bauer, G. R., Hammond, R., Travers, R., Kaay, M., Hohenadel, K. M., & Boyce, M. (2009). "I don't think this is theoretical; this is our lives": How erasure impacts health care for transgender people. *Journal of the Association of Nurses in AIDS Care*, *20*(5), 348–361. https://doi.org/10.1016/j.jana.2009.07.004. Medline:19732694

Bauer, G. R., Pyne, J., Francino, M. C., & Hammond, R. (2013). Suicidality among trans people in Ontario: Implications for social work and social justice. *Service Social*, *59*(1), 35–62. https://doi.org/10.7202/1017478ar

Bauer, G. R., & Scheim, A. I. (2015). *Transgender people in Ontario, Canada: Statistics to inform human rights policy*. London, ON.

Bauer, G. R., Scheim, A. I., Deutsch, M. B., & Massarella, C. (2014). Reported emergency department avoidance, use, and experiences of transgender persons in Ontario, Canada: results from a respondent-driven sampling survey. *Annals of Emergency Medicine*, *63*, 713–720. https://doi.org/10.1016/j.annemergmed.2013.09.027. Medline:24184160

Bauer, G. R., Scheim, A. I., Pyne, J., Travers, R., & Hammond, R. (2015). Intervenable factors associated with suicide risk in transgender persons: A respondent driven sampling study in Ontario, Canada Health behavior, health promotion and society. *BMC Public Health*, *15*(1). https://doi.org/10.1186/s12889-015-1867-2. Medline:26032733

Bauer, G. R., Zong, X., Scheim, I. A., Hammond, R., & Thind, A. (2016). Factors impacting transgender patients' discomfort with their family physicians: A respondent driven sampling study. *PLoS ONE*, *10*(12), e0145046. https://doi.org/10.1371/journal.pone.0145046. Medline:26678997

This advance access version may differ slightly from the final published version

Blodgett, N., Coughlan, R., & Khullar, N. (2018). Overcoming the barriers in transgender healthcare in rural Ontario: Discourses of personal agency, resilience, and empowerment. *International Social Science Journal*, *67*(225–226), 83–95. https://doi.org/10.1111/issj.12162.

Bradford, N. J., & Syed, M. (2019). Transnormativity and transgender identity development: A master narrative approach. *Sex Roles*, *81*(5–6), 306–325. https://doi.org/10.1007/s11199-018-0992-7.

Braun, V., & Clark, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101.

Brown, H. M., Rostosky, S. S., Reese, R. J., Gunderson, C. J., Kwok, C., & Ryser-Oatman, T. (2020). Blessing or BS? The therapy experiences of transgender and gender nonconforming clients obtaining referral letters for gender affirming medical treatment. *Professional Psychology: Research and Practice*, *51*(6), 571–579. https://doi.org/10.1037/pro0000274.

Buxton, R. (2016, February 2). This trans man's breast cancer nightmare exemplifies the problem with transgender health care. *HuffPost Canada*. https://www.huffingtonpost.ca/entry/transgender-health-care_n_7587506

Canadian Medical Association [CMA]. (2014). *Policy resolution GC 14–38—Integration of sex/gender diversity education into medical school curricula and programs*. CMA2015. Halifax: Reports to General Council. https://www.cma.ca/Assets/assets-library/document/en/about-us/gc2015/delegate-info/2015-report-to-gc-e.pdf

Clark, B. A., Marshall, S. K., & Saewyc, E. M. (2020). Hormone therapy decision-making processes: Transgender youth and parents. *Journal of Adolescence*, *79*, 136–147. https://doi.org/10.1016/j.adolescence.2019.12.016. Medline:31972534

Coutin, A., Wright, S., Li, C., & Fung, R. (2018). Missed opportunities: Are residents prepared to care for transgender patients? A study of family medicine, psychiatry, endocrinology, and urology residents. *Canadian Medical Education Journal*, *9*(3), e41–e55. https://doi.org/10.36834/cmej.42906. Medline:30140346

Davis, C. E. (in press). Trans theory & intimate partner violence. *Theory in Action*.

Davis, C. E., Coleman, T., Wilson, C., McLaren, E., Silk, W., Schmid, E., Travers, R., Luu, K., Mulholland, A., Bell, J., Ashtianti, S., & The OutLook Study Team. (2018). *Experiences of trans people in Waterloo region* (pp. 1–19). Wilfrid Laurier University, Waterloo, Ontario.

DeJong, C., Holt, K., Helm, B., & Morgan, S. J. (2021). "A human being like other victims": The media framing of trans homicide in the United States. *Critical Criminology*, *29*(1), 131–149. https://doi.org/10.1007/s10612-021-09559-z

Frothingham, S. (2015, August). *Twenty Years After Tyra Hunter's Death, LGBT People Are Still Waiting For Basic Protections.* Generation Progress. https://genprogress.org/on-20th-anniversary-of-tyra-hunters-death-lgbt-people-are-still-waiting-for-basic-protections/

Fung, R., Gallibois, C., Coutin, A., & Wright, S. (2020). Learning by chance: Investigating gaps in transgender care education amongst family medicine, endocrinology, psychiatry and urology residents. *Canadian Medical Education Journal*, *11*(4), e19–e28. https://doi.org/10.36834/cmej.53009. Medline:32821299

Giblon, R., & Bauer, G.R. (2017). Health care availability, quality, and unmet need: A comparison of transgender and cisgender residents of Ontario, Canada. *BMC Health Services Research*, *17*(1), 283. https://doi.org/10.1186/s12913-017-2226-z. Medline:28420361

Graham, R., Berkowitz, B., Blum, R., Bockting, W., Bradford, J., de Vries, B., Garofalo, R., Herek, G., Howell, E., Kasprzyk, D. and Makadon, H. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Institute of Medicine.

Grant, J. M., Mottet, L. A., Tanis, J., Herman, J. L., Harrison, J., & Keisling, M. (2010). *National transgender discrimination survey report on health and health care*. National Center for Transgender Equality and the National Gay and Lesbian Task Force.

Green, E. and Peterson, E. N. (2006). *LGBTTSQT terminology. riverside, CA: Trans-academics, lgbtresource center*. www.trans-academics.org

Haug, F. (1987). *Female sexualization: A work of collective memory* (E. Carter, Trans.). Verso Publishing.

Haug, F. (1992). *Beyond female masochism: Memory-work and politics*. Verso Books.

Haug, F. (1998). *Memory work—Guidelines for research*. Unpublished manuscript.

Health Services Branch of The Ministry of Health and Long-Term Care. (2016, March 1). *INFOBulletin: Insured sex reassignment surgery* (Bulletin #: 4666). http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/4000/bul4666.pdf

James, A. (2020, August 7). 25 years ago, Tyra hunter died due to medical transphobia, sparking international change. *The WOW Report*. https://worldofwonder.net/25-years-ago-tyra-hunter-died-due-to-medical-transphobia/

Johnson, C. W. (2018). *Collective memory work: A methodology for Learning with and from lived experience*. Routledge.

Johnson, C. W., & Parry, D. C. (2015). *Fostering social justice through qualitative inquiry: A methodological guide*. Routledge.

Lane, R. (2009). Trans as bodily becoming: Rethinking the biological as diversity, not dichotomy. *Hypatia*, *24*(3), 136–157. https://doi.org/10.1111/j.1527-2001.2009.01049.x

Nussbaum, M. C. (2003). Capabilities as fundamental entitlements: Sen and social justice. *Feminist Economics*, *9*(2–3), 33–59. https://doi.org/10.1080/1354570022000077926.

Roen, K. (2001). "Either/or" and "both/neither": Discourse tensions in transgender politics. *Signs, 27*, 501-522.

Sen, A. (1990). Development as capability expansion. *Human Development and the International Development Strategy for the 1990s*, 41–58. https://doi.org/10.1007/978-1-349-21136-4_3.

Serano, J. (2007). *Whipping girl: A transsexual woman on sexism and the scapegoating of femininity*. Seal Press.

Snelgrove, J. W., Jasudavisius, A. M., Rowe, B. W., Head, E. M., & Bauer, G. R. (2012). "Completely out-at-sea" with "two-gender medicine": A qualitative analysis of physician- side barriers to providing healthcare for transgender patients. *BMC Health Services Research*, *12*, 110. https://doi.org/10.1186/1472-6963-12-110. Medline:22559234

Socías, M. E., Marshall, B. D., Arístegui, I., Romero, M., Cahn, P., Kerr, T., & Sued, O. (2014). Factors associated with healthcare avoidance among transgender women in Argentina. *International Journal for Equity in Health*, *13*(1), 81. https://doi.org/10.1186/s12939-014-0081-7. Medline:25261275

Spade, D. (2015). *Normal life: Administrative violence, critical trans politics, and the limits of law*. Duke University Press.

The Trans PULSE Canada Team. (2020, January). *QuickStat #2 – Primimary care and unmet health needs*.Trans Pulse Canada. https://transpulsecanada.ca/research-type/quickstats/

Thompson-Blum, D. N, Coleman, T. A, Phillips, N. E., Richardson, S., Travers, R., Coulombe, S., Wilson, C., Woodford, M., Cameron, R., & Davis, C. (2021). Experiences of transgender participants in emergency departments: Findings from the OutLook Study. *Transgender Health*.

Vipond, E. (2015). Resisting Transnormativity: challenging the medicalization and regulation of trans bodies. *Theory in Action*, *8*(2), 21–44. https://doi.org/10.3798/tia.1937-0237.15008.

This advance access version may differ slightly from the final published version